		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041830

Facility Name: Heartland Health Care Center-Moline

Address: 833 16th Avenue (Number) Moline (City) 61625 (Zip Code)

County: Rock Island

Telephone Number: (309)764-6744 **Fax #** (309)764-8176

IDPA ID Number: 344402510012

Date of Initial License for Current Owners: 1966

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President of Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	129	Skilled (SNF)	139	48,925	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	129	TOTALS	139	48,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		3,478	3,937	7,415	8
9	SNF/PED					9
10	ICF	5,201	34,974	102	40,277	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,201	38,452	4,039	47,692	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.48%

D. How many bed-hold days during this year were paid by Public Aid?
16 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/16/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 3,849

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 123/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	219,526	15,644	(2,589)	232,581	1,371	233,952		233,952			1
2	Food Purchase		231,572		231,572		231,572	(2,287)	229,285			2
3	Housekeeping	116,568	13,370	1,215	131,153		131,153		131,153			3
4	Laundry	55,414	10,281	104	65,799		65,799		65,799			4
5	Heat and Other Utilities			135,271	135,271	6,519	141,790	(6,249)	135,541			5
6	Maintenance	34,925	4,761	26,993	66,679		66,679		66,679			6
7	Other (specify):* Med Waste			1,537	1,537		1,537		1,537			7
8	**TOTAL General Services**	426,433	275,628	162,531	864,592	7,890	872,482	(8,536)	863,946			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	1,498,410	128,609	5,498	1,632,517	30,326	1,662,843		1,662,843			10
10a	Therapy	150,488	1,094	8,768	160,350		160,350		160,350			10a
11	Activities	110,797	7,571	924	119,292		119,292		119,292			11
12	Social Services	69,089	1,129	1,016	71,234		71,234		71,234			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,828,784	138,403	26,706	1,993,893	30,326	2,024,219		2,024,219			16
	C. General Administration											
17	Administrative	120,847		261,369	382,216	(83,276)	298,940		298,940			17
18	Directors Fees											18
19	Professional Services			2,339	2,339	(325)	2,014	(2,014)				19
20	Dues, Fees, Subscriptions & Promotions			54,543	54,543		54,543	(41,437)	13,106			20
21	Clerical & General Office Expenses	147,675	30,393	(2,373)	175,695	325	176,020	(44,254)	131,766			21
22	Employee Benefits & Payroll Taxes			479,243	479,243	10,088	489,331		489,331			22
23	Inservice Training & Education			1,514	1,514		1,514		1,514			23
24	Travel and Seminar			20,647	20,647		20,647		20,647			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			95,180	95,180		95,180		95,180			26
27	Other (specify):*											27
28	**TOTAL General Administration**	268,522	30,393	912,462	1,211,377	(73,188)	1,138,189	(87,705)	1,050,484			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,523,739	444,424	1,101,699	4,069,862	(34,972)	4,034,890	(96,241)	3,938,649			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Health Care Center-Moline #0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			317,520	317,520	34,972	352,492		352,492			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,908	96,908		96,908		96,908			32
33	Real Estate Taxes			81,446	81,446		81,446	2,513	83,959			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,957	2,957		2,957		2,957			35
36	Other (specify):*											36
37	**TOTAL Ownership**			498,831	498,831	34,972	533,803	2,513	536,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		335,759	11,845	347,604		347,604		347,604			39
40	Barber and Beauty Shops			19,575	19,575		19,575		19,575			40
41	Coffee and Gift Shops	101,994			101,994		101,994		101,994			41
42	Provider Participation Fee			73,117	73,117		73,117		73,117			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	101,994	335,759	104,537	542,290		542,290		542,290			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,625,733	780,183	1,705,067	5,110,983		5,110,983	(93,728)	5,017,255			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,287)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,249)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,890)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(10,924)	21		16
17	Non-Care Related Fees	(4,220)	21		17
18	Fines and Penalties	(7,040)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,014)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,079)	21		24
25	Fund Raising, Advertising and Promotional	(41,437)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	2,513	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Misc. Inc.	(101)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,728)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (93,728)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heartland Health Care Center-Moline

ID# 0041830

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,287)	0	0	0	0	0	0	0	0	0	0	(2,287)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,249)	0	0	0	0	0	0	0	0	0	0	(6,249)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,536)	0	0	0	0	0	0	0	0	0	0	(8,536)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,014)	0	0	0	0	0	0	0	0	0	0	(2,014)	19
20	Fees, Subscriptions & Promotions	(41,437)	0	0	0	0	0	0	0	0	0	0	(41,437)	20
21	Clerical & General Office Expenses	(44,254)	0	0	0	0	0	0	0	0	0	0	(44,254)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(87,705)	0	0	0	0	0	0	0	0	0	0	(87,705)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(96,241)	0	0	0	0	0	0	0	0	0	0	(96,241)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Heartland Health Care Center-Moline** **#** **0041830** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	2,513	0	0	0	0	0	0	0	0	0	0	2,513	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,513	0	0	0	0	0	0	0	0	0	0	2,513	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,728)	0	0	0	0	0	0	0	0	0	0	(93,728)	45

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 261,369	HCR ManorCare, Inc.	100.00%	$ 261,369	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	9,000	Heartland Management Services	100.00%	9,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 270,369			$ 270,369	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	680,609	406,990	4,884,668	1,371	2
3	5	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	154,435		4,884,668	372	3
4	5	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	3,051,710		4,884,668	6,147	4
5	10	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	10,993,908	7,606,940	4,884,668	26,495	5
6	10	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	1,902,166	1,264,589	4,884,668	3,831	6
7	17	General & Admin - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	14,112,784	11,038,075	4,884,668	34,012	7
8	17	General & Admin - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	71,533,109	46,622,737	4,884,668	144,081	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	2,156,484		4,884,668	5,197	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	2,428,174		4,884,668	4,891	10
11	30	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	101,489		4,884,668	245	11
12	30	Depreciation - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	17,241,472		4,884,668	34,727	12
13										13
14		Interest				12,439,256				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 136,795,596	$ 66,939,331		$ 261,369	25

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Purchase Facility	Oct-91		$ 389,893	$ 389,893			$ 15,923	1
2	Bank of America		X	Finance Capital Additions	Mar-97		869,574	869,574			35,512	2
3	Bank of America		X	Finance Capital Additions	Nov-97		102,930	102,930			4,204	3
4	Bank of America		X	Finance Capital Additions	June-01			899,646			36,740	4
5	Bank of America		X	Finance Capital Additions	Sept.-01			110,901			4,529	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$104,737.00		$ 1,362,397	$ 2,372,944			$ 96,908	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,362,397	$ 2,372,944			$ 96,908	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 78,933	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 81,446	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,513	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 81,446	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 83,959	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	45,157	8
	1997	74,178	9
	1998	77,472	10
	1999	78,933	11
	2000	81,446	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0041830

CONTACT PERSON REGARDING THIS REPORT Craig Dekany, Reimbursement Manager

TELEPHONE (419) 252-5740 FAX #: (419) 252-5548

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-533-28-00	(See Attached)	$ 20,361.41	$ 20,361.41
2.	08-533-28-00	(See Attached)	$ 20,361.41	$ 20,361.41
3.	08-533-28-00	(See Attached)	$ 20,361.41	$ 20,361.41
4.	08-533-28-00	(See Attached)	$ 20,361.41	$ 20,361.41
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,445.64	$ 81,445.64

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,321 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1983	$ 116,915	1
2			1996	106,824	2
3	TOTALS			$ 223,739	3

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1966	1966	$ 1,033,964	$	30	$	$	$ 1,033,964	4
5				1983	56,519		5			56,519	5
6	10			1998	1,398,475	77,980	10-20	77,980		299,574	6
7	10										7
8											8
	Improvement Type**										
9	Leasehold Improvements (Current Year Depreciation)					148,343		148,343		1,090,241	9
10	Leasehold Improvements			1971	26,975						10
11	Leasehold Improvements			1972	1,481						11
12	Leasehold Improvements			1973	2,593						12
13	Leasehold Improvements			1974	271						13
14	Leasehold Improvements			1975	4,140						14
15	Leasehold Improvements			1976	16,237						15
16	Leasehold Improvements			1977	10,225						16
17	Leasehold Improvements			1978	5,160						17
18	Leasehold Improvements			1981	28,386						18
19	Leasehold Improvements			1982	14,373						19
20	Leasehold Improvements			1983	22,737						20
21	Leasehold Improvements			1984	5,789						21
22	Land Improvements			1985	1,470						22
23	Building Improvements			1985	109,949						23
24	Building Improvements			1986	25,262						24
25	Building Improvements			1987	16,145						25
26	Land Improvements			1987	707						26
27	Building Improvements			1988	204,870						27
28	Building Improvements			1989	3,273						28
29	Building Improvements			1990	22,292						29
30	Building Improvements			1991	8,230						30
31	Land Improvements			1991	4,771						31
32	Building Improvements			1992	16,985						32
33	Building Improvements			1993	21,450						33
34	Building Improvements			1994	51,438						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Land Improvements	1995	980						38
39	Building Improvements	1995	32,598						39
40	Land Improvements: Sign, Landscatping, and Concrete Bumpers	1996	25,027						40
41	Building Improvements: Painting/Wallcovering, Carpet, Paging system,	1996	126,134						41
42	doors/fixtures,millwork,air conditioning, moving/storage, cabinets,								42
43	hand rails,electrical wiring, ceramic tile, and bathroom sinks								43
44	Building Improvements: Fire alarm	1996	45,151						44
45	Building Improvements: Intercom system	1996	27,230						45
46	Building Improvements: Renovation of lobby, foyer, busines office:	1996	94,414						46
47	architect and engineering fees, interior design costs, drywall and								47
48	corner guards, aluminum chips, electrical heating, air conditioning								48
49	fire stop installation and access doors, and storage fees								49
50	Building Improvements: Wallcovering	1996	118,024						50
51	Building Improvements: Sewer Runs	1997	10,708						51
52	Building Improvements: Wallcovering, Floor Carpet, Cabinets,	1997	120,159						52
53	door frames, millwork, carpetry, caulking, ceilings plaster,								53
54	plumbing comosite, electrical composite, sinks, conduit wiring,								54
55	door closing devices, nurses call system								55
56	Building Improvements: 18 Bed Addition, wallcovering, conncrete,	1997	334,930						56
57	doors wood, telephone system, fencing wire, electrical transformer,								57
58	HVAC, hollow metal doors, duct work								58
59	Building Improvements: Install HVAC, electrical composite	1997	291,760						59
60	Building Improvements: Roof Replacement	1997	49,483						60
61	Building Improvements: Door	1997	1,042						61
62	Building Improvements: Siding on new additon	1997	4,993						62
63	Building Improvement: VWC from Inventory	1997	1,464						63
64	Land Improvements: Sign	1997	593						64
65	Land Improvements: Landscaping	1997	801						65
66	Land Improvements: Fence	1997	5,422						66
67	Bldg. Improvements: Cupola	1998	5,440						67
68	Bldg. Improvements: HVAC	1998	23,069						68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,433,589	$ 226,323		$ 226,323	$	$ 2,480,298	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,433,589	$ 226,323		$ 226,323	$	$ 2,480,298	1
2									2
3	Bldg. Improvements: Roof	1998	8,203						3
4	Bldg. Improvements: Electrical Work for Renovation	1998	32,459						4
5	Bldg. Improvements: Add't HVAC	1998	15,464						5
6	Bldg. Improvements: 8 Bed Addition	1998	88,423						6
7	Building Improvements: Light Fixtures for Nurses Station	1998	2,211						7
8	Land Improvements: Grading	1998	1,779						8
9	Bldg. Improvements: Wall covering, charting system, compressor	1998	35,511						9
10	Bldg. Improvements: Doors	1998	10,151						10
11	Asphalt Work	1999	14,164						11
12	Smoking Shelter	1999	5,254						12
13	Overhead from Const	1999	29,447						13
14	Concrete Pad for Smoking	1999	924						14
15	Exit Device	1999	474						15
16	Carpet	1999	994						16
17	Carpet	1999	553						17
18	Awning	1999	2,788						18
19	Building Decorations	1999	653						19
20	Retainage for Carpet	1999	73						20
21	Retainage Fee for Carpet	1999	59						21
22	Wallboard	1999	568						22
23	Wiring	1999	3,850						23
24	Wall, Drain Lines, Electrica	1999	15,776						24
25	Boiler Pump	2000	5,433						25
26	HVAC Upgrade	2000	1,600						26
27	Boiler room exhuast	2000	5,684						27
28	Phone line	2000	800						28
29	Phone line	2000	800						29
30	Ceramic tile	2000	511						30
31	Carpet	2000	842						31
32	Sinks & faucet	2000	1,055						32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,720,090	$ 226,323		$ 226,323	$	$ 2,480,298	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,720,090	$ 226,323		$ 226,323	$	$ 2,480,298	1
2									2
3	Addt'l cost sinks	2000	218						3
4	Addt'l cost carpeting	2000	59						4
5	Addt'l cost carpet	2000	94						5
6	Retainer on boiler room exhaust	2000	632						6
7	Replace door in laundry	2000	4,932						7
8	Bldg Imprv - Carpentry/Wallcovering	2001	11,535						8
9	Bldg Imprv - Carpentry/Electrical	2001	60,645						9
10	Bldg Imprv - Wallcovering	2001	11,630						10
11	Land Imprv - Concrete work	2001	4,941						11
12	Land Imprv - Walkway & Canopy	2001	3,858						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,818,633	$ 226,323		$ 226,323	$	$ 2,480,298	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,359,496	$ 91,197	$ 91,197	$		$ 931,141	71
72	Current Year Purchases	94,063						72
73	Fully Depreciated Assets							73
74	Home Office Allocation		34,972	34,972				74
75	TOTALS	$ 1,453,559	$ 126,169	$ 126,169	$		$ 931,141	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van With		$ 22,049	$	$	$		$ 22,049	76
77		Chair Lift								77
78										78
79										79
80	TOTALS			$ 22,049	$	$	$		$ 22,049	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,517,980	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 352,492	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 352,492	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,433,488	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,957 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2205 hrs	$ 51,598	137	$ 3,420	$ 405	2,342	$ 55,423	1
2	Licensed Speech and Language Development Therapist	10a	151 hrs	3,540	47	1,170	77	198	4,787	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4075 hrs	95,350	167	4,178	582	4,242	100,110	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				335,759		335,759	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): IV Ther, Lab, Pharm	10a,39				11,845	30		11,875	13
14	TOTAL			$ 150,488	351	$ 20,613	$ 336,853	6,782	$ 507,954	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 24,824	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (33,868))	445,361		3
4	Supply Inventory (priced at)	6,114		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	875		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 477,174	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	288,252		13
14	Buildings, at Historical Cost	4,754,119		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,475,608		16
17	Accumulated Depreciation (book methods)	(3,433,488)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,084,491	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,561,665	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 50,913	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,902		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,446		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	25,826		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 366,087	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,372,944		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,372,944	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,739,031	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 822,634	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,561,665	$	48

***(See instructions.)**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,110,346	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,110,346	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,170,550	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,170,550	17
	B. Transfers (Itemize):		
18	**Change In Interdivision**	(3,458,262)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,458,262)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 822,634	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,479,423	1
2	Discounts and Allowances for all Levels	(81,978)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,397,445	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	426,880	6
7	Oxygen	(30)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 426,850	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,968	12
13	Barber and Beauty Care	24,119	13
14	Non-Patient Meals	646	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	345,043	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70,572	19
20	Radiology and X-Ray	900	20
21	Other Medical Services	12,889	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 457,137	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	101	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 101	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,281,533	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	864,592	31
32	Health Care	1,993,893	32
33	General Administration	1,211,377	33
	B. Capital Expense		
34	Ownership	498,831	34
	C. Ancillary Expense		
35	Special Cost Centers	542,290	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,110,983	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,170,550	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,170,550	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,828	2,000	$ 49,642	$ 24.82	1
2	Assistant Director of Nursing	3,703	4,052	70,375	17.37	2
3	Registered Nurses	10,454	11,438	187,332	16.38	3
4	Licensed Practical Nurses	30,969	33,886	429,496	12.67	4
5	Nurse Aides & Orderlies	79,064	86,510	730,930	8.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,602	6,432	150,488	23.40	7
8	Rehab/Therapy Aides					8
9	Activity Director	10,791	11,807	110,797	9.38	9
10	Activity Assistants					10
11	Social Service Workers	3,837	4,199	69,089	16.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,405	26,705	219,526	8.22	15
16	Dishwashers					16
17	Maintenance Workers	2,078	2,274	34,925	15.36	17
18	Housekeepers	13,803	15,105	116,568	7.72	18
19	Laundry	6,112	6,687	55,414	8.29	19
20	Administrator	3,159	2,080	120,847	58.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,060	8,622	147,675	17.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,822	1,994	30,635	15.36	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	10,498	10,498	101,994	9.72	33
34	TOTAL (lines 1 - 33)	216,185	234,289	$ 2,625,733 *	$ 11.21	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	10,500	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,500		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Vicki Toomsen	Sr. Administrator	0	$ 120,847
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 120,847

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 261,369
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 261,369

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Fees for legal	$ 2,014
Grantly Payne & Assoc	Consul. Fees	325
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 2,339

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,476
Unemployment Compensation Insurance	28,439
FICA Taxes	196,120
Employee Health Insurance	204,564
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	16,857
Employee Appreciation	6,655
Other Employee Benefits	836
Employee Uniforms	296
Home Office Allocations	10,088
TOTAL (agree to Schedule V, line 22, col.8)	$ 489,331

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 354
Advertising: Employee Recruitment	3,039
Health Care Worker Background Check (Indicate # of checks performed 54)	1,080
Dues/Subscriptions	6,302
Advertising Allowable	2,298
Advertising Non-Allowable	41,437
Marketing/Lecture	33
Less: Public Relations Expense	( )
Non-allowable advertising	(41,437)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,106

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,571
Includes trips to Toledo, OH (Corporate) for regional meetings.	
Seminar Expense	
Auto Expense	4,076
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,647

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5800**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **50,848** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Moline Nurs & Rehab Center #33084 Transferred to HCR of America 8/15/96

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **73,117**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **646**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.